

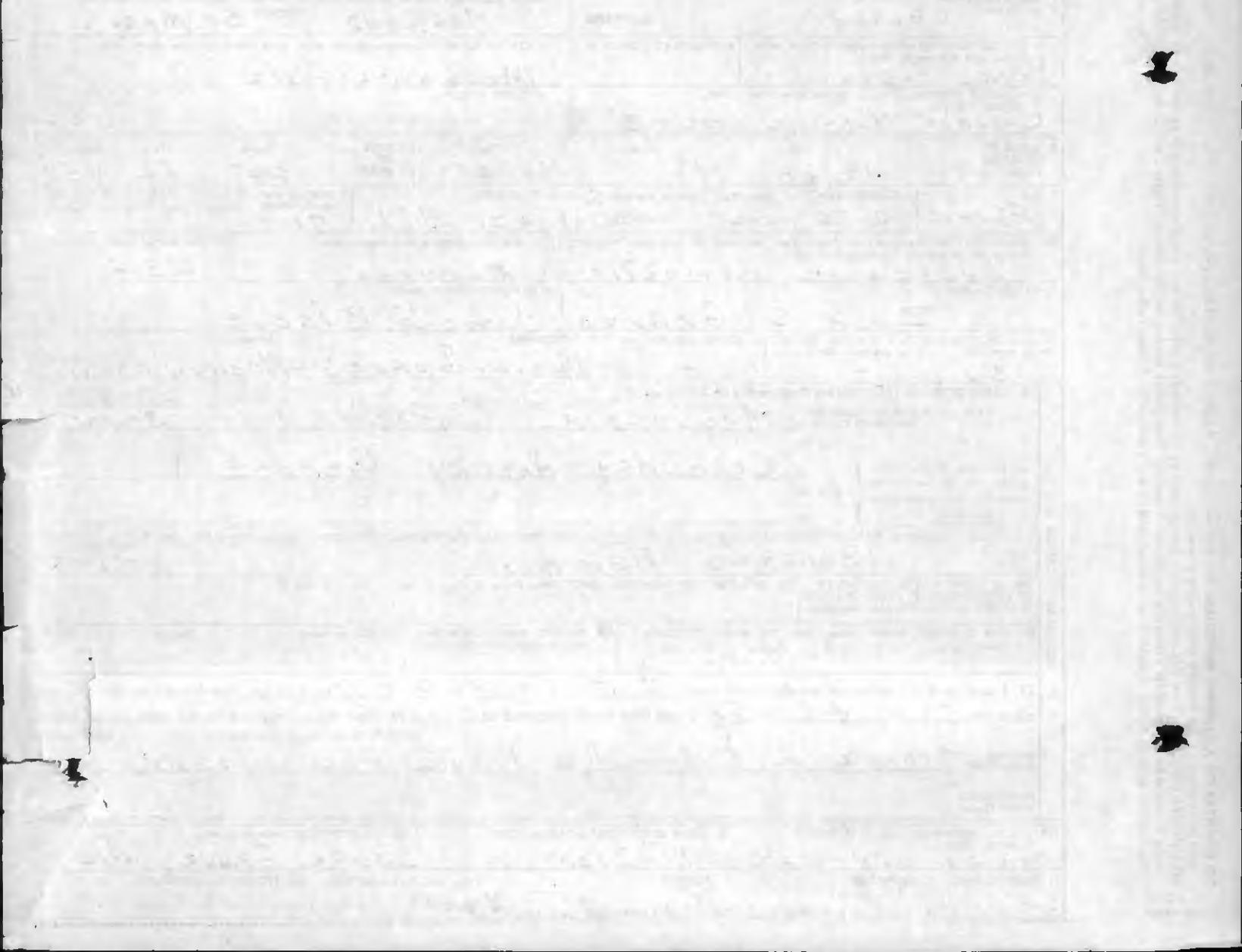
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11132 CERTIFICATE OF DEATH

Reg. Dist. No.

11125

1. PLACE OF DEATH a. COUNTY CALVERT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCE FREDERICK		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CALVERT NURSING HOME		d. STREET ADDRESS Mechanicville 18	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LAURA M.	Middle BEBEE	4. DATE OF DEATH Oct. 22 1958
5. SEX FEMALE	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 21, 1887
9. AGE (In years lost birthday) 71 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife domestic		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Zack S. Graves		14. MOTHER'S MAIDEN NAME Jane E. Biscoe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT		Address Mrs. L. Graves - Mechanicsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) CORONARY ARTERY DISEASE DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH, 30 min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PARALYSIS AGITANS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 1, 1958 to OCT 22, 1958, that I last saw the deceased alive on OCT 14, 1958, and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Merle L. Gibson, M.D.		ADDRESS (Street, city or town, state) Prince Frederick, Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED Oct. 22, 1958	
22a. BURIAL, CREMATION, REMOVAL, (Specify) BURIAL		22b. DATE THEREOF 10-25-58	
22c. NAME OF CEMETERY OR CREMATORIAL MT. ZION		22d. LOCATION (City, town, or county) Laurel Grove	
(State)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR	
ADDRESS		DATE OCT 30 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

STATE OF DELAWARE—DEPARTMENT OF STATE
REGISTRATION OF DEATHS



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

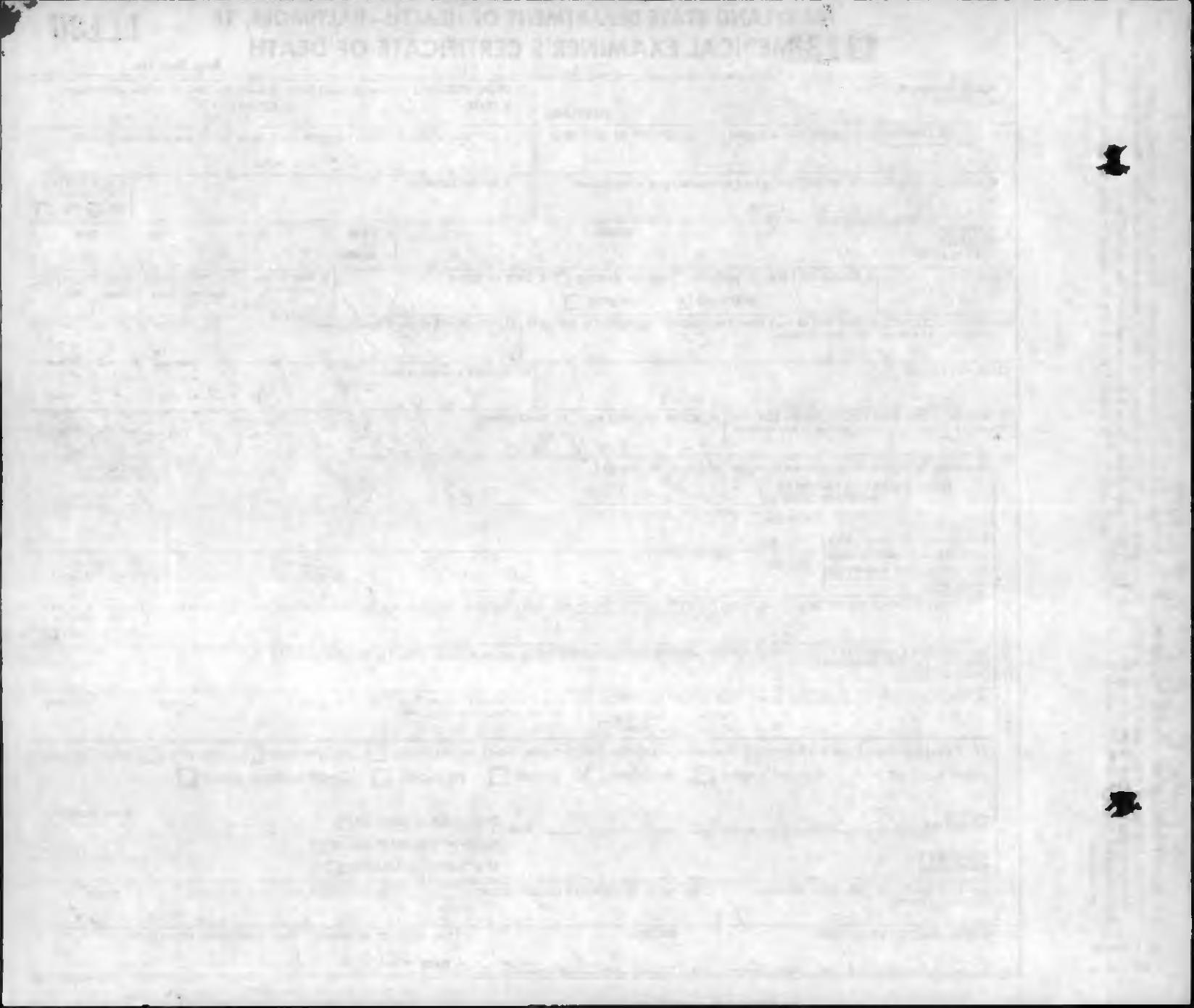
11126

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1D Film C 235 10/31/58 pg

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		Reg. Dist. No.	
<i>Calvert</i>		b. STATE			
MARYLAND		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Princedale</i>				<i>Mt. Victoria</i> 08X2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Calvert Nursing Home					
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
<i>John</i>			<i>Clark</i>	10	24 1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.
<i>M</i>			<i>July 24 1877</i>	81 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Fisher</i>		<i>Farming</i>		<i>Red</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<i>John W Clark</i>		<i>Margaret Blackhall</i>		<i>England</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No known) (If yes, give rank or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
<i>No</i>		<i>217-32-2194</i>		<i>Mrs. Magdalene Shae Alter</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Cardiac vascular cerebral disease</i> 10 yrs			
<i>442x</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>	(b) <i>Eye</i>	DUE TO <i>Jaundice of retina</i>	(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>H.W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)		DATE SIGNED <i>10/23/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>10-26-58</i>		<i>Princedale Cemetery</i> <i>Mt. Victory</i> <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 29 '58	
<i>Richard Lee Zepola</i>				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



11127

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in the certifying office, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transtil Permit. File Pages 1 and 2 with the registrar prior to serial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1113 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film #25 10-21-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Sunderland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>Md</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sunderland</i>		c. LENGTH OF STAY IN 1b <i>1</i>				
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sunderland</i>		e. STREET ADDRESS <i>1</i>				
f. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Rachel</i>	Middle <i>Coates</i>	Last <i>10</i>			
4. DATE OF DEATH Month <i>Oct</i>	Day <i>7</i>	Year <i>1958</i>				
5. SEX <i>F</i>	6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1862 Oct 1874 196</i>			
9. AGE (In years at birthday) yrs. <i>96</i>	10. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>None</i>			
13. FATHER'S NAME <i>Ben Smith</i>	14. MOTHER'S MAIDEN NAME <i>Rachel Brown</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				
16. SOCIAL SECURITY NO. <i>4442X</i>	17. INFORMANT <i>Ernest Cooley</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac vascular syndrome</i>				
DUE TO (b) <i>Age</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>				
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Nie死亡 in clean at home</i>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>					
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	Month, Day, Year <i>10-11-58</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>Sunderland</i>	(County) <i>None</i>	(State) <i>Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>H.W. Ward</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <i>10/15/58</i>		
EXAMINER'S NAME (Type) <i>None</i>						
22a. BURIAL) CREMATION, REMOVAL (Specify) <i>None</i>	22b. DATE THEREOF <i>10-11-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Hope</i>		22d. LOCATION (City, town, or county) <i>Sunderland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Sewell</i>		ADDRESS <i>Prince Frederick</i>	24a. RECD BY REGISTRAR DATE OCT 14 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Knapp</i>	

1945

December

Sept 1st 20 31

December 2nd 20 31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11135

CERTIFICATE OF DEATH

11128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willows		d. STREET ADDRESS X Willows	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First Audrey Gregory	Middle	Last	4. DATE OF DEATH	Month October	Day 6	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1886	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Mays		14. MOTHER'S MAIDEN NAME Willie McGrow					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs. Audrey Gregory, Willows, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 days	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oct.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 3, 1958 , to Oct. 6, 1958 , that I last saw the deceased alive on Oct. 6, 1958 , and that death occurred at 8:20 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Merle L. Gibson Jr.				ADDRESS (Street, city or town, state) Prince Frederick, Md.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10-9-58		22c. NAME OF CEMETERY OR CREMATORIUM Lees Crematorium		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home -		ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR DATE OCT 10 '58		24b. REGISTRAR'S SIGNATURE Curvin S. Krause	

RECORDED STATE OF TEXAS
ATTACHMENT TO DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11136

CERTIFICATE OF DEATH

11129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Solomons</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Solomons</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. STREET ADDRESS —	
3. NAME OF DECEASED (Type or print) <i>James R. Grover</i>		First <i>J</i>	Middle <i>R.</i>
4. DATE OF DEATH <i>Oct. 27, 1958</i>		Month <i>Oct.</i>	Day <i>27</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Jan. 23, 1876</i>		9. AGE (In years lost birthday) <i>82 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>8</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Buliding</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>	11. BIRTHPLACE (State or foreign country) <i>Calvert Co., Md</i>
13. FATHER'S NAME <i>Robert R. Grover</i>		14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Wells</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-10-0706</i>	17. INFORMANT <i>Kennedy Brown - Solomons, Md</i>
		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177X</i>		Carcinomatous	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO <i>Ca 7 prostate</i>			
DUE TO <i>Ca 7 prostate</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan. 1957</i> , to <i>Oct. 27, 1958</i> , that I last saw the deceased alive on <i>Oct. 27, 1958</i> , and that death occurred at <i>Md</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>St. Leonard</i>	
ACTUAL SIGNATURE <i>R. de VILLARREAL</i>		DATE SIGNED <i>10/27/58</i>	
PHYSICIAN'S NAME (Type) <i>R. de VILLARREAL</i>		ST. LEONARD	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 29, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Paul's Cem.</i>
22d. LOCATION (City, town, or county) <i>Burly, Calvert Co., Md</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Starkness & Son - Mutual, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 31 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

MANUFACTURE STATEMENT OF NAME—NUMBER
CERTIFICATE OF DEATH

1998

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1998

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11137

CERTIFICATE OF DEATH

11130

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldville</i>		c. LENGTH OF STAY IN lb <i>1b</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>Calvert</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. STREET ADDRESS <i>X Wall Ville</i>		f. DATE OF DEATH <i>10 15 1958</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>JAMES</i>	Middle <i>S.</i>	Last <i>HOOKS</i>	4. DATE OF BIRTH <i>Sept. 9,</i>	Month <i>75 yrs.</i>	Day <i>10</i>	Year <i>1958</i>	5. AGE (In years last birthday) IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>	Min. <i></i>
S. SEX <i>m.</i>	6. COLOR OR RACE <i>C.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 9,</i>	9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Charles A. Hooks.</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Jane Murray</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>		16. SOCIAL SECURITY NO. <i>317-32-4657</i>		17. INFORMANT <i>Hattie Hooks St. Leonard's Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>40 yrs.</i>		DUE TO <i>Coronary thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i></i>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Generalized arteriosclerosis</i>		(c) <i></i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20f. (City or town) <i></i>		(County) <i></i>		(State) <i></i>					
21. I certify that I attended the deceased from <i>Sept 15, 1958</i> to <i>Oct 15, 1958</i> that I last saw the deceased alive on <i>Oct 15, 1958</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i></i>		DATE SIGNED <i>Stephenson</i>							
ACTUAL SIGNATURE <i>R. E. Stephens</i>		M.D.									
PHYSICIAN'S NAME (Type) <i></i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>10-18, 58</i>		22b. DATE THEREOF <i>10-18, 58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Browns</i>		22d. LOCATION (City, town, or county) <i>Island Creek, Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell</i>		ADDRESS <i>Prince Frederick</i>		24a. REC'D. BY REGISTRAR <i>Oct 21, 58</i>		24b. REGISTRAR'S SIGNATURE <i></i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11138

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	b. COUNTY <i>Baltimore</i>
c. LENGTH OF STAY IN 1b <i>Since October</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>Lee</i>	Last <i>Hooper</i>	4. DATE OF DEATH Month <i>Oct</i>	Month <i>22</i>	Day <i>19</i>	Year <i>58</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/21/42</i>	9. AGE (in years last birthday) yrs. <i>70</i>	10. UNDER 1 YEAR Months <i>0</i>	11. UNDER 24 HRS. Hours <i>0</i>	12. UNDER 24 HRS. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waiter</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				

13. FATHER'S NAME <i>William O. Hooper Jr.</i>	14. MOTHER'S MAIDEN NAME <i>Lucille Wood</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>No</i>	Address <i>William O. Hooper Jr., Principal, Md.</i>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>22-8</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Deceased at my Civil of</i> (c) <i>West, due to an accident</i>	INTERVAL BETWEEN ONSET AND DEATH <i>—</i>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>caused by a fall from a chair.</i>	

20c. TIME OF INJURY Hour <i>X. 7 p.m.</i>	Month, Day, Year <i>10/22/58</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Residence</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md</i>
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
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ACTUAL SIGNATURE <i>H. Lee Hooper</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>10/22/58</i>
EXAMINER'S NAME (Type) <i>—</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct 25, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Crestview Cemetery</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Calvert Co., Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. G. Harness & Son, Mutual, Md.</i>	ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR <i>Oct 27 '58</i>	24b. REGISTRAR'S SIGNATURE <i>John S. Kline</i>



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11132

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and file page 5 within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		11139		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)		Reg. Dist. No.	
Calvert		MARYLAND		a. STATE Md		b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Huntingtown		Life		Huntingtown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Doy
Quinton M Mackall					Oct	12	Year 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	
M		C	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 25 May 1953	5 yrs	Months Days	Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
none		—		Md		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Joseph D Mackall		Melvina V. Dixon					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
(If yes, give war or dates of service)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7826 Malnutrition dehydration							
DUE TO Conditions, if any, which gave rise to immediate cause (b) Diarrhea							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>J. J. Wellens</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)		DATE SIGNED <i>10/12/58</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Burial		Oct. 13, '58		St. Edwards Church		Chesapeake Beach, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REG. STRK		24b. REGISTRAR'S SIGNATURE	
<i>Leroy E. Berry Huntingtown</i>				OCT 15 '58		<i>Lewis L. Mann</i>	
VS. A15ME SM 2.57				DATE			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11140

CERTIFICATE OF DEATH

11133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Fred.</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Fred., Md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>/</i>		d. STREET ADDRESS <i>/</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i></i>	Last <i>Mason</i>		
4. DATE OF DEATH	Month <i>10</i>	Day <i>4</i>	Year <i>1958</i>		
S SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 23,</i>		
9. AGE (In years last birthday) <i>82 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. IF UNDER 24 HRS Hours <i></i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house wife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Richard Jefferson</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>	Address <i>Mrs. Selma Joyce Prince Fred., Md</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>23IX</i>	16. SOCIAL SECURITY NO <i></i>	17. INFORMANT <i></i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular Accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i></i>	INTERVAL BETWEEN ONSET AND DEATH <i>2-3 hrs.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i></i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>Dead on arrival</i> , 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <i>9 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Merle L. Gibson Jr. M.D.</i>	ADDRESS (Street, city or town, state) <i>Prince Frederick, Md</i>			DATE SIGNED <i></i>	
22a. BURIAL/CREMATION, REMOVAL (Specify) <i>10-8-58</i>	22b. DATE THEREOF <i>10-8-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olive</i>	22d. LOCATION (City, town, or county) <i>Prince Fred., Md</i>	(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell, Prince Fred., Md</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR <i>OCT 14 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Civilian Health</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11134

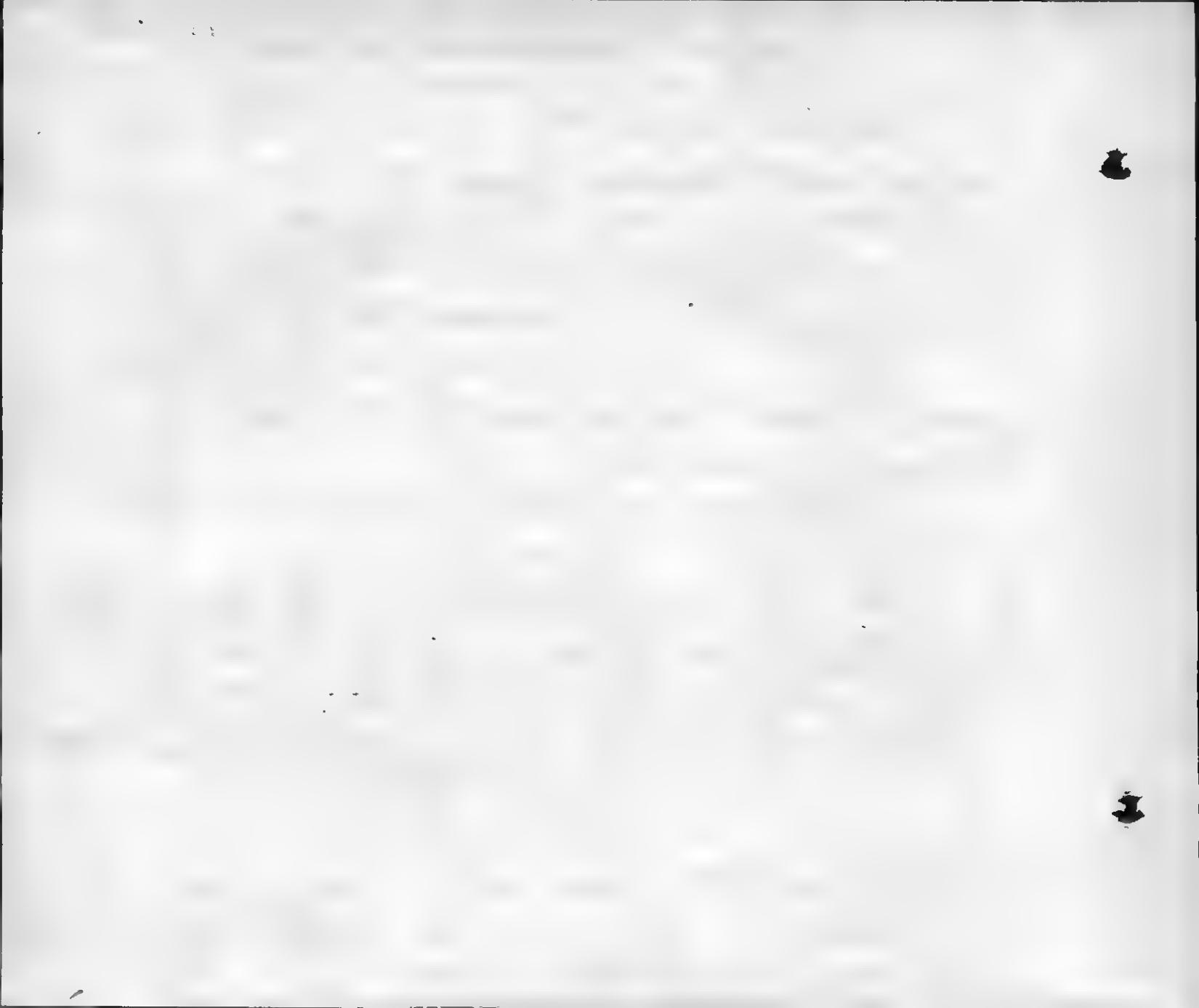
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <i>MD</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Montgomery Village</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Clarendon Co.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>Harold</i>	Middle <i>W.</i>	Last <i>Hughes</i>					
4. DATE OF DEATH Month <i>Oct</i>	Day <i>23</i>	Year <i>1958</i>						
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <i>Sept 15 1900</i>	9. AGE (In years last birthday) <i>58 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. IF UNDER 24 HRS. Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Builder</i>		11. BIRTHPLACE (State or foreign country) <i>Wyo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>James W. Hughes</i>		14. MOTHER'S MAIDEN NAME <i>Esther</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes/no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-16-4544</i>		17. INFORMANT <i>Family Dr. Henry S. Van Dusen</i>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drowning</i>				INTERVAL BETWEEN ONSET AND DEATH <i>—</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>420.1</i>		DUE TO (b) _____						
		DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<i>Waterfall took him from bed at 9 P.M.</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>						
20c. TIME OF INJURY Hour <i>10</i> o. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Bedroom</i>		20f. (City or town) <i>Barstow</i>	(County) <i>Calvert</i>	(State) <i>Md</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <i>10/27/58</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 26, 1958</i>		22c. NAME OF CEMETERY OR GREMATORIUM <i>Bellevue Cemetery</i>		22d. LOCATION (City, town, or county) <i>Barstow - Calvert - Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. O. Harkness & Son - Mutual, Md</i>		ADDRESS <i>—</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 27 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>		



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11142 CERTIFICATE OF DEATH

11135

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	CALVERT PRINCE FREDERICK 11700 HOSPITAL OR INSTITUTION OR STREET ADDRESS	MARYLAND LENGTH OF STAY (In this place)	STATE MARYLAND COUNTY CALVERT CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Prince Frederick STREET ADDRESS
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH Oct. 24, 1958	
5. SEX F	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M	8. DATE OF BIRTH July 26, 1914
9. AGE last birthday 44 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 21505-7568	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
13. FATHER'S NAME PETER SWIESKOSKI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 215-05-7568	17. INFORMANT & ADDRESS Milton E. Myers, Jr., (son)
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
1. X IMMEDIATE CAUSE Metastatic Carcinoma of Lung ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Carcinoma of Breast 10 mo.			
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION Jan. 1958		19b. MAJOR FINDINGS OF OPERATION carcinoma of Breast	
19c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 1, 1958, to Oct. 24, 1958, that I last saw the deceased alive on Oct. 24, 1958, and that death occurred at 2:30 A.M. from the causes and on the date stated above.			
SIGNATURE Mule L. Gibson Jr.		ADDRESS (Street, city, town, state) Prince Frederick, Md. DATE SIGNED 10/24/58	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 10-27-58	NAME OF CEMETERY OR CREMATORIALy
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	LOCATION (City, town, or county) BALTIMORE CO. MD
DATE OCT 27 58		25. FUNERAL DIRECTOR'S SIGNATURE John J. Kebey	
		ADDRESS 401 S. Chestnut St	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11143

CERTIFICATE OF DEATH

11136

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cabret</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		C. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) <i>Fusby</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. STREET ADDRESS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>-</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Howard J. Pardoe</i>		First	Middle	Last	4. DATE OF DEATH <i>Oct. 20, 1958</i>	Month	Day	Year			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 6, 1885</i>	9. AGE (in years lost birthday) yrs. <i>76</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>James Pardoe</i>	14. MOTHER'S MAIDEN NAME <i>Sarah Jane Buckley</i>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO <i>213-40-8348</i>	17. INFORMANT <i>Wyatt Pardoe - Fusby, Md</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of Bowel</i> DUE TO <i>153.9</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)						19. INTERVAL BETWEEN ONSET AND DEATH <i>5 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20d. INJURY OCCURRED White Not white	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Fusby</i>	(County)	(State)				
21. I certify that I attended the deceased from <i>Oct. 1, 1958</i> , to <i>Oct. 20, 1958</i> , that I last saw the deceased alive on <i>Oct. 20, 1958</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Merle L. Gibson Jr. M.D.</i> ADDRESS (Street, city or town, state) <i>Prince Frederick, Md</i> DATE SIGNED <i>10/22/58</i>										22. PHYSICIAN'S NAME (Type) <i>MERLE L. GIBSON JR. PRINCE FREDERICK, MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct. 23, 1958</i>	22c. NAME OF CEMETERY OR Crematory <i>Middleham Chapel</i>	22d. LOCATION (City, town, or county) <i>Fusby - Cabret Co - Md</i>	(State)							
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness & Son - Mutual, Md</i>	ADDRESS	24a. REC'D BY REGISTER <i>OCT 24 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>								



11144

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11137

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oceanside</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oceanside Beach Md</i>	
c. LENGTH OF STAY IN 1b <i>Calvert</i>		d. STREET ADDRESS <i>1000 Beach Rd. Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <i>Calvert</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Jessie</i>	First <i>Jessie</i>	Middle <i>Robertson</i>	Last <i>10</i>
4. DATE OF DEATH <i>10/19/58</i>	Month <i>10</i>	Day <i>19</i>	Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/11/81</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Food Service</i>	11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	12. CITIZEN OF WHAT COUNTRY? <i>None</i>
13. FATHER'S NAME <i>Thomas W Shelton</i>	14. MOTHER'S MAIDEN NAME <i>Sarah E Jones</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>579-22-0028</i>	17. INFORMANT <i>John Robertson</i>	Address <i>Oceanside Beach Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO <i>104.0</i> Conditions, if any, which gave rise to immediate cause (b) <i>Weakened hips</i> DUE TO <i>fall at home</i> (c) <i>fall at home</i>			
			INTERVAL BETWEEN ONSET AND DEATH <i>37 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Brief nature of injury in Part I or Part II of item 18.) <i>fall at home</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>9/12</i> p. m. <i>1958</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> or work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
20f. (City or town) <i>Oceanside Beach Md</i>		(County) <i>Calvert</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>H.W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H.W. Ward</i>		DATE <i>11/24/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-22-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Washington National Cemetery</i>	22d. LOCATION (City, town, or county) <i>Oceanside Beach Md</i> (State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. W. Ward</i>	ADDRESS <i>1000 Beach Rd. Md.</i>	24a. REC'D BY REGISTRAR <i>John Robertson</i>	24b. REGISTRAR'S SIGNATURE <i>John Robertson</i>
24c. DATE <i>11/24/59</i>		24d. SIGNATURE <i>John Robertson</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

Replacement: Film 238 - 1-28-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11138

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY		11145		2. USUAL RESIDENCE [If deceased lived in another place before admission]	
<i>Healy about 11145</i>		MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]		c. LENGTH OF STAY IN lb		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] ✓	
<i>St. Leonard's</i>				<i>Oliver Chapin</i>	
d. NAME OF HOSPITAL OR INSTITUTION [If not in hospital, give street address]				d. STREET ADDRESS <i>431/2 Clarendon Blvd</i>	
3. NAME OF DECEASED (Type or print)		First <i>Joseph</i>	Middle <i>A.</i>	Last <i>Rosasco</i>	4. DATE OF DEATH Month Day Year <i>Oct 10 4 1958</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>WIDOWED</i> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>3/1/90</i>	9. AGE (In years last birthday) <i>87</i>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY <i>Govt. Printing Office</i>		11. BIRTHPLACE (State or foreign country) <i>WASH. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>BARTHELOMEW</i>		14. MOTHER'S MAIDEN NAME <i>MAGDALEINE Crovo</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT/ <i>Mrs. Gayline H. Brodt = 4812 Cheveron Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute debilitation of heart</i>				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Coronary occlusion</i>		DUE TO (b) <i>Coronary occlusion</i>			
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Delayed death due to slow of the heart</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20f. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) <i>Had had spells of epix type</i>			
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State) <i>Prince Georges Co. Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>H. Edward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>George Noy 10/4/58</i>	
EXAMINER'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/8/58</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Co. Washington, D. C.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>OCT 8 58</i>	24b. REGISTRAR'S SIGNATURE <i>L. E. Truett</i>
VS. A15ME(S) SM 9/55					



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11146 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11139

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>4 months</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John J. Smith</i>		First <i>J.</i>	Middle <i>John</i>
4. DATE OF DEATH <i>16 Oct 58</i>		Month <i>Oct</i>	Day <i>16</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>18 Feb 1888</i>		9. AGE (In years and birthday) <i>70 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Businessman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Business</i>	11. BIRTHPLACE (State or foreign country) <i>England</i>
12. CITIZEN OF WHAT COUNTRY? <i>England</i>		13. FATHER'S NAME <i>John J. Smith</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>491X</i>		17. INFORMANT <i>Daughter</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart attack</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>	
Conditions, if any, which gave rise to immediate cause (b) <i>Arteriosclerosis</i>			
DUE TO (c) <i>High blood pressure</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> ; Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>F W Ward</i>		DATE SIGNED	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/28/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Edmunds Church, Sunderland, Md.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George E. Berry, Huntington, Md.</i>		ADDRESS <i>1146</i>	
		24a. REC'D BY REGISTRAR <i>Oct 29 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>John S. Evans</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11147

CERTIFICATE OF DEATH

11140

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN lb 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Randall Cliffs Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		d. STREET ADDRESS /		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Margaret		First Middle Last Wenzel		4. DATE OF DEATH October		Month 25	Day 19	Year 58
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1910		9. AGE (in years last birthday) 47 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Thomas Robinson		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO —		
17. INFORMANT Forest Wenzel		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Address Randall Cliffs, Md.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. Huntington, Md.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8 Oct , 1958, to 25 Oct , 1958, that I last saw the deceased alive on 25 Oct , 1958, and that death occurred at 11 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Huntington, Md.		DATE SIGNED 26 Oct 58
ACTUAL SIGNATURE J. J. Weems		PHYSICIAN'S NAME (Type) J. J. Weems		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-28-58	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) Bladensburg Rd. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home (Owings) Md		ADDRESS —		24a. REC'D BY REGISTRAR DATE OCT 28 '58		24b. REGISTRAR'S SIGNATURE J. J. Weems		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11148

CERTIFICATE OF DEATH

11141

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician, and completely filled in by the funeral director. OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Calvert</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tunkirk</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tunkirk</i>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Elizabeth</i>	Middle <i>Whetlington</i>	Lost	4. DATE OF DEATH	Month 10	Day 26	Year 1958	
S. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 26,</i>	9. AGE (In years lost birthday) <i>81 yrs.</i>	IF UNDER 1 YEAR Months <i>81</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Pamel Jones</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte Holt</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Harriett Smith</i>		Address <i>Tunkirk, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 coronary artery disease</i>									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>generalized arteriosclerosis</i>									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Tunkirk</i>		(County) <i>Calvert</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>Sept 5, 1958</i> to <i>Oct 21, 1958</i> , that I last saw the deceased alive on <i>Oct 10, 1958</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <i>Tunkirk</i>									DATE SIGNED <i>10-21-58</i>
ACTUAL SIGNATURE <i>Donald A. Wilson</i>		M.D. <i>L. Wilson</i>							
PHYSICIAN'S NAME (Type)									
22a. BURIAL/CREMATION, REMOVAL (Specify) <i>cremation</i>		22b. DATE THEREOF <i>Oct 26 - 58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Halls Creek</i>		22d. LOCATION (City, town, or county) <i>Tunkirk</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. E. Sewell</i>		ADDRESS <i>Prince Frederick</i>		24a. REC'D BY REGISTRAR <i>OCT 27 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

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Chlorophyll a/b ratio
Photosynthetic pigments

Br. do Brasil Março de 1940

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2, see birth certificate *gg*
CERTIFICATE OF DEATH

11142

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Calvert				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Plum Point				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				d. STREET ADDRESS ---				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Baby Boy		First	Middle	Lost	4. DATE OF DEATH Wills	Month October	Day 25	Year 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/21/58	9. AGE (in years last birthday) yrs. 5	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Wills				14. MOTHER'S MAIDEN NAME Shirley Jones				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — (c) DUE TO DUE TO DUE TO								
INTERVAL BETWEEN ONSET AND DEATH Premature (2 lbs - 12 oz) (Breach presentation)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Oct 22 , 1958, to Oct 25 , 1958, that I last saw the deceased alive on Oct 25 , 1958, and that death occurred at M , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>R. W. Williams</i>		ADDRESS (Street, city or town, state) 57th Avenue DATE SIGNED 1958						
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-26-58		22b. DATE THEREOF 10-26-58		22c. NAME OF CEMETERY OR CREMATORIAL Plum Point		22d. LOCATION (City, town, or county) Calvert (State) MD		
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell</i>		ADDRESS <i>Prince Fred. Md.</i>		24a. REC'D BY REGISTRAR DATE OCT 31 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DATA

2

Year Month

10 x 12 x 10 ft.

10 ft. x 10 ft. x 10 ft.